

Composite of the

SOCIAL SECURITY ACT

And

H. R. 1

THE "SOCIAL SECURITY AMENDMENTS OF 1972"

AS ENACTED OCTOBER 30, 1972

VOLUME II

TITLE XVIII OF THE SOCIAL SECURITY ACT



**DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION**

Bureau of Retirement and
Survivors Insurance

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INTRODUCTION

This Composite Act has been prepared to reflect the changes made by H.R. 1, "The Social Security Amendments of 1972," in the Social Security Act, pertinent provisions of the Internal Revenue Code of 1954, and provisions of other laws relating to the Social Security Act.

The materials used to prepare this Composite consist of portions of the Composite Act included in the report of the Senate Finance Committee, Senate Report No. 92-1230, and a copy of the engrossed bill, H.R. 1, presented to the President for his approval.

This Composite consists of four volumes. Volume I contains title II. Volume II contains title XVIII. Volume III contains title XI. Volume IV contains other titles of the Social Security Act, pertinent provisions of the Internal Revenue Code of 1954, and provisions of other laws relating to the Social Security Act and sections of H.R. 1 which have an effect on the Social Security Act but which are not a part of the Act.

In this Composite Act, provisions which will be deleted or repealed are enclosed in boldface brackets or are stricken through. Provisions which are added are in italics, or in larger size type double spaced, or inserted in the right-hand margin of the page; or, in the case of some extensive changes, are in roman type cut from pages of the enrolled bill. In addition, all changes are accompanied by a reference in the left-hand margin of the page to the appropriate section of the amending bill.

Section references in the footnotes, unless otherwise indicated, are to sections of H.R. 1.

Division of Technical Services
Regulations and Rulings Branch

(i)

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Prohibition Against Any Federal Interference

Sec. 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Free Choice by Patient Guaranteed

Sec. 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

Option to Individuals To Obtain Other Health Insurance Protection

Sec. 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

Sec. 1811. The insurance program for which entitlement is established by section 226 provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system and (2) *individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits*

Sec. 1812(a)

§201(a)(2)

under title II of this Act or under the railroad retirement system on the basis of a disability.

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.

(e) For purposes of subsections (b), (c), and (d), inpatient hospital services, inpatient psychiatric hospital services, post-hospital extended care services, and post-hospital home health services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

Deductibles and Coinsurance

Sec. 1813. (a) (1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a) (1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

Sec. 1813(b)

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

(b) (1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) shall be \$40 in the case of any spell of illness beginning before 1969.

(2) The Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) in the case of any spell of illness beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to \$40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of \$4 shall be rounded to the nearest multiple of \$4 (or, if it is midway between two multiples of \$4, to the next higher multiple of \$4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1866, to individuals who are entitled to hospital insurance benefits under section 226, plus the amount which would have been so paid but for subsection (a) (1) of this section.

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

- § 226(c) (1) **Sec. 1814. (a)** [Except as provided in subsection (d)] *Except as provided in subsections (d) and (g)¹ and in section 1876,² payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—*
- § 227(b) (1) *(1) written request, signed by such individual, except in cases*

¹ Applies to accounting periods beginning after December 31, 1972.
² Effective with respect to services provided on or after July 1, 1973.

§281(e)

in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

3/

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition non-communicable;

[(C) in the case of post-hospital extended care services, such services are or were required to be given on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services]

§247(a)

(C) *in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services,*¹ (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) [and (8)] and (9)² of section 1861(e)) prior to transfer to the [extended care facility]

§234(g)(1)

¹ Applies with respect to services furnished after December 31, 1972.

² Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

3/ Applies to services furnished or deemed to have been furnished after 1970. Sec. 281(g).

Sec. 1814(a)

skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services; **[or]**

§234(g)(1)

(D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) **[and (8)]** and (9)¹ of 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; *or*

(E) *in the case of inpatient hospital services in connection with a dental procedure, the individual suffers from impairments of such severity as to require hospitalization;*²

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

² Applies to admissions occurring after the second month following the month of enactment.

§278(a)(2)

may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or **[extended care facility]** *skilled nursing facility*, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

§238(a)

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, **[as described in section 1861(k)(4)]** *as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution*)¹ pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or **[extended care facility]** *skilled nursing facility*, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

[Reasonable Cost of Services] Amount Paid to Providers³

(b)(1) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be—**[the reasonable cost of such services, as determined under section 1861(v)]**

§233(a)

(1) the lesser of (A) the reasonable cost of such services, as determined under section 1861(v), or (B) the customary charges with respect to such services; or

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services.

³ Applies to services furnished by hospitals, skilled nursing facilities, and home health agencies in accounting periods beginning after December 31, 1972.

Sec. 1814(c)

No Payments to Federal Providers of Services

(c) No payment may be made under this part (except under subsection (d)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

Payments for Emergency Hospital Services

(d) (1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement

Sec. 1814(f)

may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for the services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or legal holiday) after the day on which such admission occurred.

[Payment for Certain Emergency Hospital Services Furnished Outside the United States] *Payment for Certain Inpatient Hospital Services Furnished Outside the United States*¹

[(f) The authority contained in subsection (d) shall be applicable to emergency inpatient hospital services furnished an individual by a hospital located outside the United States if—

[(1) such individual was physically present in a place within the United States at the time the emergency which necessitated such inpatient hospital services occurred; and

[(2) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.]

(f) (1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more acces-

¹ Applies to services furnished with respect to admissions occurring after December 31, 1972.

Sec. 1814(g)

sible from the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State: at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of section 1813, be equal to the amount which would be payable under subsection (d) (3).

Payment for Services of a Physician Rendered in a Teaching Hospital *Z*

§227(b)(2)

(g) For purposes of services for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if—

1/ Applies to accounting periods beginning after June 30, 1973.

Sec. 1814(i)

(1) such hospital has an agreement with the Secretary under section 1866, and

(2) the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care of hospital patients or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged, provision will be made for return of any moneys incorrectly collected).

Payment for Posthospital Extended Care Services^{1,2}

(h) (1) An individual shall be presumed to require the care specified in subsection (a) (2) (C) of this section for purposes of making payment to an ~~extended care~~ facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

(A) the certification referred to in subsection (a) (2) (C) of this section is submitted prior to or at the time of admission of such individual to such ~~extended care~~ facility.

(B) such certification states that the medical condition of the individual is a condition designated in regulations.

(C) such certification is accompanied by a plan of treatment for providing such services, and

(D) there is compliance with such other requirements and procedures as may be specified in regulations.

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

Payment for Posthospital Home Health Services^{1,2}

(i) (1) An individual shall be presumed to require the services specified in subsection (a) (2) (D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

(A) the certification and plan referred to in subsection (a) (2)

¹ Applies to admissions to skilled nursing facilities initiated on or after January 1, 1973.

² Applies to home health plans initiated on or after January 1, 1973.

skilled nursing

skilled nursing

§228(a)

Sec. 1814(j)

(D) of this section are submitted in timely fashion prior to the first visit by such agency,

(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

(C) there is compliance with such other requirements and procedures as may be specified in regulations,

§228(a)

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1) ~

Payment to Providers of Services

Sec. 1815. The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Use of Public Agencies or Private Organizations To Facilitate Payment to Providers of Services

Sec. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (~~subject to~~ *subject to the provisions of section 1878 and to*¹ such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of this part, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part.

(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement.

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may,

¹ Applies to cost reports of providers of services, as defined in title XVIII of the Act, for accounting periods ending on or after June 30, 1973.

Sec. 1816(d)

upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

(f) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(g) (1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) or (2).

Federal Hospital Insurance Trust Fund

Sec. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hos-

§ 132(d)

pital Insurance Trust Fund” (hereinafter in this section referred to as the “Trust Fund”). The Trust Fund shall consist of *such gifts and bequests as may be made as provided in section 201(i)(1)*, and ¹ such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by section 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the “Board of Trustees”) composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the “Managing Trustee”). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund dur-

¹ Applies to gifts and bequests received after the date of enactment.

Sec. 1817(c)

ing the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) (1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him

as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary of Health, Education, and Welfare shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

Hospital Insurance Benefits for Uninsured Individuals Not Otherwise Eligible

Sec. 1818. (a) Every individual who—

(1) has attained the age of 65,

(2) is enrolled under part B of this title,

(3) is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this section, and

(4) is not otherwise entitled to benefits under this part,
shall be eligible to enroll in the insurance program established by this part.

Sec. 1818(b)

(b) An individual may enroll under this section only in such manner and form as may be prescribed in regulations, and only during an enrollment period prescribed in or under this section.

(c) The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (c) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—

(1) individuals who meet the conditions of subsection (a) (1), (3), and (4) on or before the last day of the seventh month after the month in which this section is enacted may enroll under this part and (if not already so enrolled) may also enroll under part B during an initial general enrollment period which shall begin on the first day of the second month which begins after the date on which this section is enacted and shall end on the last day of the tenth month after the month in which this Act is enacted;

(2) in the case of an individual who first meets the conditions of eligibility under this section on or after the first day of the eighth month after the month in which this section is enacted, the initial enrollment period shall begin on the first day of the third month before the month in which he first becomes eligible and shall end 7 months later;

(3) in the case of an individual who enrolls pursuant to paragraph (1) of this subsection, entitlement to benefits shall begin on—

(A) the first day of the second month after the month in which he enrolls,

(B) July 1, 1973, or

*(C) the first day of the first month in which he meets the requirements of subsection (a),
whichever is the latest;*

(4) termination of coverage under this section by the filing of notice that the individual no longer wishes to participate in the hospital insurance program shall take effect at the close of the month following the month in which such notice is filed;

(5) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226 of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement; and

(6) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act.

(d) (1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be \$33.

(2) The Secretary shall, during the last calendar quarter of each year, beginning in 1973, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months

occurring in the 12-month period commencing July 1 of the next year. Such amount shall be equal to \$33, multiplied by the ratio of (A) the inpatient hospital deductible for such next year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest multiple of \$1, or if midway between multiples of \$1 to the next higher multiple of \$1.

(e) Payment of the monthly premiums on behalf of any individual who meets the conditions of subsection (a) may be made by any public or private agency or organization under a contract or other arrangement entered into between it and the Secretary if the Secretary determines that payment of such premiums under such contract or arrangement is administratively feasible.

(f) Amounts paid to the Secretary for coverage under this section shall be deposited in the Treasury to the credit of the Federal Hospital Insurance Trust Fund.

Sec. 1831

**Part B—Supplementary Medical Insurance Benefits for the Aged
and Disabled**

**Establishment of Supplementary Medical Insurance Program for
the Aged and the Disabled**

Sec. 1831. There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for **[individuals 65 years of age or over]** *aged and disabled individuals* who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

Scope of Benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

- (1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in paragraph (2) (B); and
- (2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

- (A) home health services for up to 100 visits during a calendar year;

- (B) medical and other health services **[(other than physicians' services unless furnished by a resident or intern of a hospital and the services for which payment may be made pursuant to section 1835(b) (2))]** furnished by a provider of services or by others under arrangements with them made by a provider of services; **[and]** ¹, *excluding—*

- (i) *physician services except where furnished by—*

- (I) *a resident or intern of a hospital, or*

- (II) *a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, and*

- (ii) *services for which payment may be made pursuant to section 1835(b)(2); and* ¹

- (C) outpatient physical therapy **[services.]** *services, other than services to which the next to last sentence of section 1861(p) applies.*²

- (b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

1/ Applies to accounting periods beginning after June 30, 1973.

2/ Applies to services furnished on or after July 1, 1973.

Payment of Benefits

§226(c)(2)

Sec. 1833. (a) **[Subject to]** *Except as provided in section 1876, and subject to*¹ the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

2/

(1) in the case of services described in section 1832(a)(1)—
80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), **[and]** (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) *with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, and (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and*

1/

§211(c)(4)

§279(a)

(2) in the case of services described in section 1832(a)(2)—

§299K(a)

with respect to home health services,
100 percent, and with respect to other
services, 80

3/

¹ Applies to services furnished with respect to admissions occurring after December 31, 1972.

2/ Applies to services provided on or after July 1, 1973.

3/ Applies to services furnished by home health agencies in accounting periods beginning after December 31, 1972.

percent of [of the reasonable cost of the services (as determined under section 1861 (v)).]

(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

§233(b)

(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b) (2).

1/

§251(a)(3)

“(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services.”

2/

§204(a)

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of ~~\$50~~, except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied

\$60 3/

1/ Applies to services furnished by hospitals, extended care facilities, and home health agencies in accounting periods beginning after December 31, 1972.

2/ Applies to services furnished on or after July 1, 1973.

3/ Effective with respect to calendar years after 1972 (except that, for purposes of applying clause (1) of the first sentence of section 1833(b), the provisions of section 204 of the amendments are deemed to have taken effect on January 1, 1972).

Sec. 1833(c)

toward such individual's deductible under this section for such preceding year, and (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined) ; and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

- (1) \$312.50, or
- (2) 62½ percent of such expenses.

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) (1) In the case of the purchase of durable medical equipment included under section 1861(s) (6), by or on behalf of an individual, payment shall be made in such amounts as the Secretary determines to be equivalent to payments that would have been made under this part had such equipment been rented and over such period of time as the Secretary finds such equipment would be used for such individual's medical treatment, except that [with respect to purchases of inexpensive equipment (as determined by the Secretary)] (A) payment may be made in a lump sum if the Secretary finds that such method of payment is less costly or more practical than periodic payments, and (B) with respect to purchases of used equipment the Secretary is authorized to waive the

Sec. 1835(a)

20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of such equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

§245(d) (2) In the case of rental of durable medical equipment, the Secretary may, pursuant to agreements made with suppliers of such equipment, establish any reimbursement procedures (including payment on a lump sum basis in lieu of prolonged rental payments) which he finds to be equitable, economical, and feasible.

§279(b) (g) With respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the Secretary is authorized to establish a payment rate which is acceptable to the laboratory and which would be considered the full charge for such tests. Such negotiated rate shall be limited to an amount not in excess of the total payment that would have been made for the services in the absence of such a rate.

§251(a) (2) (g) In the case of services described in the next to last sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than \$100 shall be considered as incurred expenses for purposes of subsections (a) and (b). 21

Limitation on Home Health Services

Sec. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.

Procedure for Payment of Claims of Providers of Services

§227(e) (2) (A) Sec. 1835. (a) Except as provided in [subsections (b) and (c)] subsections (b), (c), and (e),¹ payment for services described in section 1832(a) (2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

[(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulations prescribe; and]

§281(f) (1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient admin-

¹ Applies to accounting periods beginning after ~~December 31, 1972~~ June 30, 1973.

Sec. 1835(a)

*istration so requires, such period may be reduced to not less than 1 calendar year; and*¹

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; and

§251(b)(2) (C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services [on an outpatient basis],² (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

§283(b) (D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

3/

¹ Applies in the case of services furnished (or deemed to have been furnished) after 1970.

² Applies to items furnished on or after date of enactment.

3/ Applies to services rendered after December 31, 1972.

For purpose of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services as therein defined ,

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

(b)(1) Payment may also be made to any hospital for services described in section 1861(s) furnished as an outpatient service by a hospital or by others under arrangements made by it to an individual entitled to benefits under this part even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has made an election pursuant to section 1814(d)(1)(C) with respect to the calendar year in which such emergency services are provided. Such payments shall be made only in the amounts provided under section 1833(a)(2) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may also be made on the basis of an itemized bill to an individual for services described in paragraph (1) of this subsection if (A) payment cannot be made under such paragraph (1) solely because the hospital does not elect, in accordance with section 1814(d)(1)(C), to claim such payments and (B) such individual files application (submitted within such time and in such form and manner, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amounts payable under this paragraph shall, subject to the provisions of section 1833, be equal to 80 percent of the hospital's reasonable charges for such services.

(c) Notwithstanding the provisions of this section and sections 1832, 1833, and 1866(a)(1)(A), a hospital may, subject to such limitations as may be prescribed by regulations, collect from an individual the customary charges for services specified in section 1861(s) and furnished to him by such hospital as an outpatient. ~~but only if such charges for such services do not exceed \$50~~

but only if such charges for such services do not exceed the applicable supplementary medical insurance deductible,¹

, and such customary charges shall be regarded as expenses incurred by such individual with respect to which benefits are payable in accordance with section 1833(a)(1). Payments under this title to hospitals which have elected to make collections from individuals in accordance with the preceding sentence shall be adjusted periodically to place the hospital in the same position

^{1/} Effective with respect to calendar years after 1972 (except that, for purposes of applying clause (1) of the first sentence of section 1833(b), the provisions of section 204 of the amendments are deemed to have taken effect on January 1, 1972).

Sec. 1835(d)

it would have been had it instead been reimbursed in accordance with section 1833(a)(2).

(d) No payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.

§227(e)(2)(b)

(e) *For purposes of services (1) which are inpatient hospital services by reason of paragraph (7) of section 1861(b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B)(i), and (2) for which the reasonable cost thereof is determined under section 1861(v)(1)(D), payment under this part shall be made to such fund as may be designated by the organized medical staff of the hospital in which such services were furnished or, if such services were furnished in such hospital by the faculty of a medical school, to such fund as may be designated by such faculty, but only if*—

(1) *such hospital has an agreement with the Secretary under section 1866, and*

(2) *the Secretary has received written assurances that (A) such payment will be used by such fund solely for the improvement of care to patients in such hospital or for educational or charitable purposes and (B) the individuals who were furnished such services or any other persons will not be charged for such services (or if charged provision will be made for return for any moneys incorrectly collected).*

Eligible Individuals

Sec. 1836. Every individual who—

[(1) has attained the age of 65, and

[(2) (A) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, or (B) is entitled to hospital insurance benefits under part A,

is eligible to enroll in the insurance program established by this part.]

(1) *is entitled to hospital insurance benefits under part A, or*

(2) *has attained age 65 and is a resident of the United States, and is either (A) a citizen or (B) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part,*

§201(c)(1)

is eligible to enroll in the insurance program established by this part.

Enrollment Periods

Sec. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be

¹ Applies to accounting periods beginning after ~~December 31, 1972~~ June 30, 1973.

prescribed by regulations, and only during an enrollment period prescribed in or under this section.

[(b) (1) No individual may enroll for the first time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the close of the first enrollment period during which he could have enrolled under this part.

[(2) An individual whose enrollment under this part has terminated may not enroll for the second time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the effective date of such termination. No individual may enroll under this part more than twice.]

§260

(b) *No individual may enroll under this part more than twice.*

§201(c)(2)(A)

(c) In the case of individuals who first satisfy [paragraphs (1) and] *paragraph (1) or (2) of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on May 31, 1966. [For purposes of this subsection and subsection (d), an individual who satisfies paragraph (2) of section 1836 solely by reason of subparagraph (B) thereof shall be treated as satisfying such paragraph (2) on the first day on which he is (or on filing application would be) entitled to hospital insurance benefits under part A.] For purposes of this subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A.*

§201(c)(2)(B)

§201(c)(2)(C)

(d) In the case of an individual who first satisfies [paragraphs (1) and (2)] *paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later. Where the Secretary finds that an individual who has attained age 65 failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the month in which such individual attained age 65), because such individual (relying on documentary evidence) was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on his attaining age 65 at the time shown in such documentary evidence (with a coverage period determined under section 1838 as though he had attained such age at that time).*

(e) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on January 1 and ending on March 31 of each year beginning with 1969.

(f) Any individual—

¹⁶(1) who is eligible under section 1836 to enroll in the medical insurance program by reason of entitlement to hospital insurance benefits as described in paragraph (1) of such section, and

¹⁷(2) whose initial enrollment period under subsection (d) begins after March 31, 1973, and

¹⁸(3) who is residing in the United States, exclusive of Puerto Rico,

shall be deemed to have enrolled in the medical insurance program established by this part.

(g) All of the provisions of this section shall apply to individuals satisfying subsection (f), except that—

(1) in the case of an individual who satisfies subsection (f) by reason of entitlement to disability insurance benefits described in section 226(a)(2)(B), his initial enrollment period shall begin on the first day of the later of (A) April 1973 or (B) the third month before the 25th consecutive month of such entitlement, and shall reoccur with each continuous period of eligibility (as defined in section 1839(e)) and upon attainment of age 65;

(2) (A) in the case of an individual who is entitled to monthly benefits under section 202 or 223 on the first day of his initial enrollment period or becomes entitled to monthly benefits under section 202 during the first 3 months of such period, his enrollment shall be deemed to have occurred in the third month of his initial enrollment period, and

(B) in the case of an individual who is not entitled to benefits under section 202 on the first day of his initial enrollment period and does not become so entitled during the first 3 months of such period, his enrollment shall be deemed to have occurred in the month in which he files the application establishing his entitlement to hospital insurance benefits provided such filing occurs during the last 4 months of his initial enrollment period; and

(3) in the case of an individual who would otherwise satisfy subsection (f) but does not establish his entitlement to hospital insurance benefits until after the last day of his initial enrollment period (as defined in subsection (d) of this section), his enrollment shall be deemed to have occurred on the first day of the earlier of the then current or immediately succeeding general enrollment period (as defined in subsection (e) of this section).

Sec. 1838

§259(a)

(h) In any case where the Secretary finds that an individual's enrollment or nonenrollment in the insurance program established by this part or part A pursuant to section 1818 is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government, or its instrumentalities, the Secretary may take such action (including the designation for such individual of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums) as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction.¹

Coverage Period

Sec. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) **July 1, 1966** July 1, 1966 or (in the case of a disabled individual who has not attained age 65) July 1, 1973, or

§201(c)(3)(A)

¹ Effective as of July 1, 1966.

(2) (A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies [paragraphs (1) and (2)] *paragraph (1) or (2)* of section 1836, the first day of such month, or

(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such paragraph[s], the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such paragraph[s], the first day of the second month following the month in which he so enrolls, or

(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such paragraph[s], the first day of the third month following the month in which he so enrolls, or

(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls.

§206(b)

(3) (A) in the case of an individual who is deemed to have enrolled on or before the last day of the third month of his initial enrollment period, the first day of the month in which he first meets the applicable requirements of section 1836 or July 1, 1973, whichever is later, or

(B) in the case of an individual who is deemed to have enrolled on or after the first day of the fourth month of his initial enrollment period, as prescribed under subparagraphs (B), (C), (D), and (E) of paragraph (2) of this subsection.

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period [(not in excess of 90 days)]¹ in which overdue premiums may be paid and coverage continued. *The grace period determined under the preceding sentence shall not exceed 90 days; except that it may be extended to not to exceed 180 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 90-day period.*

§257(a)

¹/ Applies to nonpayment of premiums due and payable on date of enactment or which became due and payable within 90 days before enactment.

Sec. 1839

§206(c)

Where an individual who is deemed to have enrolled for medical insurance pursuant to section 1837 (f) files a notice before the first day of the month in which his coverage period begins advising that he does not wish to be so enrolled, the termination of the coverage period resulting from such deemed enrollment shall take effect with the first day of the month the coverage would have been effective and such notice shall not be considered a disenrollment for the purposes of section 1837 (b). Where an individual who is deemed enrolled for medical insurance benefits pursuant to section 1837 (f) files a notice requesting termination of his deemed coverage in or after the month in which such coverage becomes effective, the termination of such coverage shall take effect at the close of the calendar quarter following the calendar quarter in which the notice is filed.

§201(c) (3) (C)

(c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

[(c)] (d) No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period.

Amounts of Premiums

Sec. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be \$3.

§203(a)

(b) (1) The monthly premium of each individual enrolled under this part for each month after 1967 and before July 1, 1973, shall be the amount determined under paragraph (2).

§203(b)

(2) The Secretary shall, during December 1968 and of each year [thereafter] ending on or before December 31, 1971, determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the 12-month period commencing July 1 in each succeeding year. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such 12-month period will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for such 12-month period. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin. Whenever the Secretary, pursuant to the preceding sentence, promulgates the dollar amount which shall be applicable for premiums for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of premiums so promulgated.

§203(c)

(c) (1) The Secretary shall, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to those enrollees age 65 and over will equal one-half of the total of the benefits

and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such 12-month period. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after June 1973 shall, except as provided in subsection (d), be the amount determined under paragraph (3).

(3) The Secretary shall, during December of 1972 and of each year thereafter, determine and promulgate the monthly premium applicable for the individuals enrolled under this part for the 12-month period commencing July 1 in the succeeding year. The monthly premium shall be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that 12-month period, or

(B) the monthly premium rate most recently promulgated by the Secretary, under this paragraph or, in the case of the determination made in December 1971, such rate promulgated under subsection (b) (2) multiplied by the ratio of (i) the amount in column IV of the table which, by reason of the law in effect at the time the promulgation is made, will be in effect as of June 1 next following such determination appears (or is deemed to appear) in section 215(a) on the line which includes the figure "750" in column III of such table to (ii) the amount in column IV of the table which appeared (or was deemed to appear) in section 215(a) on the line which included the figure "750" in column III as of June 1 of the year in which such determination is made.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and over as provided in paragraph (1) and the derivation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during December of 1972 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the 12-month period commencing July 1 in the succeeding year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such 12-month period with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be incurred ~~by~~ the Federal Supplementary Medical Insurance Trust Fund for such 12-month period with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

[(c)] (d) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) or (c) shall be increased by 10 percent of the monthly premium so determined for each full 12

§203(c)

§203(d)(1)

fin

Sec. 1839(d)

months (*in the same continuous period of eligibility*) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time. *Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.*

§201(c)(4)

[(d)] (e) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

§203(d)(2)

[(e)] (f) *For purposes of subsection [(c)] (d) (and section 1837 (g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).*

§201(c)(5)

Payment of Premiums

§201(c)(6)(A)

Sec. 1840. (a)(1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall (except as provided in [(subsection (d))] subsections (b)(1) and (c))¹ be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

§263(a)

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 or 223 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

§201(c)(6)(B)

(b)(1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937 (*whether or not such individual is also entitled for such month to a monthly insurance benefit under section 202*), his monthly premiums

§263(b)

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

§263(b)

under this part shall (except as provided in subsection [(d)](c))¹ be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

§263(c)

[(c)] In the case of an individual who is entitled both to monthly benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply.²

[(d)] (c) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

[(e)] (d) (1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 of title 5, United States Code, may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him

¹ Applies to premiums due and payable after the fourth month following the month of enactment.

² Applies to premiums becoming due and payable after the fourth month following the month of enactment.

Sec. 1840(f)

under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other law administered by the Civil Service Commission, to the Federal Supplementary Medical Insurance Trust Fund, the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

§ 263(d)(1) [(f)] (e) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection [(d)](c)¹ applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

§ 263(d)(2) [(g)] (f) Amounts paid to the Secretary under subsection [(d)] or (f)] (c) or (e) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

[(h)] (g) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

§ 263(d)(3) [(i)] (h) In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1843 is applicable, subsection (a), (b), (c), [(d)], and (e)] and (d)² of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1843(d).

Federal Supplementary Medical Insurance Trust Fund

§ 132(e) **Sec. 1841.** (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of *such gifts and bequests as may be made as provided in section 201 (i) (1), and*³ such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

² Applies to premiums becoming due and payable after the fourth month following the month of enactment.

³ Applies to gifts and bequests received after date of enactment.

Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

- (1) Hold the Trust Fund;
- (2) Report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;
- (3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and
- (4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

Sec. 1841(d)

(d) Any obligations acquired by the Trust Fund (except public debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Civil Service Commission in making deductions pursuant to section 1840 **[(e)]**(d). During each fiscal year, or after the close of such fiscal year, the Civil Service Commission shall certify to the Secretary the amount of the costs it incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

(i) *The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Railroad Retirement Board for services performed pursuant to section 1840(b)(1). During each fiscal year or after the close of such fiscal year, the Railroad Retirement Board shall certify to the Secretary the amount of the costs it incurred in performing such services and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.*¹

Use of Carriers for Administration of Benefits

Sec. 1842. (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and

¹ Applies to premiums becoming due and payable after the fourth month following the month of enactment.

§263(d)(4)

§263(e)

1/

/ and section 1842(g)

with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services *on a reasonable charge basis*,¹ the Secretary shall to the extent possible enter into such contracts:

§ 227(e)(3)

(1) (A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2) (A) determine compliance with the requirements of section 1861(k) as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k)(2)) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b) (1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis,

¹ Applies to accounting periods beginning after ~~December 31, 1972~~

June 30, 1973.

Sec. 1842(b)

such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870 (f)) be made—

- (i) on the basis of an itemized bill; or
- (ii) on the basis of an assignment under the terms of which
- (I) the reasonable charge is the full charge for the service *(except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f))* and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;
- 2/
- 3/

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

- (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, *in any case where the amount in controversy is \$100 or more*¹ when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;
- §262(a)

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

¹ Applies to hearings requested (under the procedures established under section 1842(b)(3)(C) of the Act) after the date of enactment.

2/ Applies to services furnished with respect to admissions occurring after December 31, 1972.

3/ Applies to notices sent to individuals after 1968.

No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any fiscal year beginning after June 30, 1973, may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the ~~lower~~ charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.²

lowest

§224(a)

§258(a)

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

(5) *No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B) (ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over*

² Applies to bills submitted and requests for payment made after March 1968.

Sec. 1842(c)

§236(a)

his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service.¹

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

¹ Applies with respect to bills submitted and requests for payments made after the date of enactment.

Sec. 1842(f)

(f) For purpose of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other non-governmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

(g) *The Railroad Retirement Board shall, in accordance with such regulations as the Secretary may prescribe, contract with a carrier or carriers to perform the functions set out in this section with respect to individuals entitled to benefits as qualified railroad retirement beneficiaries pursuant to section 226(a) of this Act and section 21(b) of the Railroad Retirement Act of 1937.* ^

263(d)(5)

2/

2/ Applies to collection of premiums becoming due and payable after the fourth month following month of enactment.

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under titles I, X, XIV, and XVI, and part A of title IV.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter.

(d) In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (c) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

Sec. 1843(e)

(A) the month in which he is determined by the State agency to have become ineligible both for money payments of a kind specified in the agreement and (if there is in effect a modification entered into under subsection (h)) for medical assistance, or

(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d)(3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c).

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, X, XIV, or XVI or part A of title IV

, or eligible to receive medical assistance under the plan of such State approved under title XIX, if the agreement entered into under this section so provides, the term "carrier" as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, X, XIV, and XVI, and part A of title IV, and individuals eligible to receive medical assistance under the plan of the State approved under title XIX.

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)),

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection, and

(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such individual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month).

(h) (1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any *individual* who would (but for this subsection) be excluded from the agreement, subsections (c) and (d) (2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d) (2) (C) shall be applied by substituting "second month following the first month" for "first month."

Appropriations to Cover Government Contributions and Contingency Reserve

Sec. 1844. (a) There are authorized to be appropriated from time to time out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1) (A) a Government contribution equal to the aggregate premiums payable *for a month for enrollees age 65 and over* under this part and deposited in the Trust Fund, [and] *multiplied by the ratio of—*

(i) *twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(c) (1) for such month, minus the dollar amount of the premium per enrollee for such month as determined under section 1839(c) (3), to*

(ii) *the dollar amount of the premium per enrollee for such month, plus*

(B) a Government contribution equal to the aggregate premiums payable *for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—*

(i) *twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(c) (4) for such month, minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(c) (3), to*

(ii) *the dollar amount of the premium per enrollee for such month.*¹

§203(e)

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during

¹ Effective with respect to enrollee premiums payable for months after June 1973.

Sec. 1844(b)

the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to \$18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) The term “spell of illness” with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

§278(a)(4)

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of [an extended care] *a skilled nursing facility.*

Inpatient Hospital Services

(b) The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in the hospital [by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association.] *by—*

Sec. 1861(c)

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatry Education of the American Podiatry Association; or ^{1/}
A ^{2/}

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), unless (A) such inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients. ^{1/}
A

Inpatient Psychiatric Hospital Services

(c) The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient Tuberculosis Hospital Services

(d) The term "inpatient tuberculosis hospital services" means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) ^{3/} and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse

^{1/} Applies with respect to accounting periods beginning after ~~December 31, 1972~~ June 30, 1973.

2/ Applies to accounting periods beginning after December 31, 1972.

3/ Applies to services furnished with respect to admissions occurring after December 31, 1972.

or registered professional nurse on duty at all times except that until January 1, 1976, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individuals, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; [and]

§234(a)

(8) *has in effect an overall plan and budget that meets the requirements of subsection (z);¹ and*

(9) [(8)] meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution. [except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863).]

§244(a)

For purposes of subsection (a) (2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), *section 1814(f) (2)*,² and subsections (i) and (n) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j) (1) (A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. *For purposes of sec-*

§211(b)

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

²/ Applies to services furnished with respect to admissions occurring after December 31, 1972.

Sec. 1861(f)

tion 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals.¹

§211(b)

Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through [(8)] (9)² of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

¹Applies to services furnished with respect to admissions occurring after Dec. 31, 1971.

²Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

234(b)

Tuberculosis Hospital

§234(c)

- (g) The term "tuberculosis hospital" means an institution which—
- (1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;
 - (2) satisfies the requirements of paragraphs (3) through **[(8)]** ⁽⁹⁾ of subsection (e);
 - (3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;
 - (4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and
 - (5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Extended Care Services

§278(a)(5)

(h) The term "extended care services" means the following items and services furnished to an inpatient of **[an extended care]** *a skilled nursing facility* and (except as provided in paragraphs (3) and (6)) by such **[extended care]** *skilled nursing facility*—

- (1) nursing care provided by or under the supervision of a registered professional nurse;
- (2) bed and board in connection with the furnishing of such nursing care;
- (3) physical, occupational, or speech therapy furnished by the **[extended care]** *skilled nursing facility* or by others under arrangements with them made by the facility;
- (4) medical social services;
- (5) such drugs, biologicals, supplies, applicances, and equipment, furnished for use in the **[extended care]** *skilled nursing facility* as are ordinarily furnished by such facility for the care and treatment of inpatients;
- (6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and
- (7) such other services necessary to the health of the patients as are generally provided by **[extended care]** *skilled nursing facilities*;

1/ Applies to fiscal years of providers beginning after the fifth month after month of enactment.

Sec. 1861(i)

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services

(i) The term “post-hospital extended care services” means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the [extended care] skilled nursing facility [within 14 days after discharge from such hospital;]

(A) *within 14 days after discharge from such hospital, or*
(B) *within 28 days after such discharge, in the case of an individual who was unable to be admitted to a skilled nursing facility within such 14 days because of a shortage of appropriate bed space in the geographic area in which he resides, or* (C) *within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a hospital;* an individual shall be deemed not to have been discharged from [an extended care] a skilled nursing facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other [extended care] skilled nursing facility.

[Extended Care] Skilled Nursing Facility

(j) The term “[extended care] “skilled nursing facility” means (except for purposes of subsection (a) (2)) an institute (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; [and]

§234(d)

(10) has in effect an overall plan and budget that meets the requirements of subsection (z);¹

§246(b)

(11) supplies full and complete information to the Secretary or his delegate as to the identity (A) of each person ^{who} has any direct or indirect ownership interest of 10 per centum or more in such skilled nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such skilled nursing facility or any of the property or assets of such skilled nursing facility, (B) in case a skilled nursing facility is organized as a corporation, of each officer and director of the corporation, and (C) in case a skilled nursing facility is organized as a partnership, of each partner; and promptly reports any changes which would affect the current accuracy of the information so required to be supplied; ² A

(12) cooperates in an effective program which provides for a regular program of independent medical eval-

1/ Applies to fiscal years of providers beginning after the fifth month after month of enactment.

2/ Effective July 1, 1973.

Sec. 1861(f)

§246(b) *uation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);*

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing
homes;

/ facilities

Sec. 1861(j)

§246(b)(2)

(16) [10] meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863),

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except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution

which meets the requirements of paragraph (1) of this subsection. The term ["extended care"] "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

Notwithstanding any other

§246(b)(4)

provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act. ^{1/} _^

Sec. 1861(k)

To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) *such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,*

(B) *such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and*

(C) *such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.*

Utilization Review

(k) A utilization review plan of a hospital or [extended care] skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and [extended care] skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after oppor-

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tunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

§237(c) The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or **[extended care]** *skilled nursing* facility where, because of the small size of the institution, or (in the case of **[an extended care]** *a skilled nursing* facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. *If the Secretary determines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.*

Agreements for Transfer Between **[Extended Care]** *Skilled Nursing* Facilities and Hospitals

§278 (1) A hospital and **[an extended care]** *a skilled nursing* facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the **[extended care]** *skilled nursing* facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any **[extended care]** *skilled nursing* facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term “home health services” means the following items and services furnished to an individual, who is under the care of a

Sec. 1861(n)

physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or **extended care** *skilled nursing facility*, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Home Health Services

(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from **an extended care** *a skilled nursing facility* of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or **extended care** *skilled nursing facility*.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

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(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; [and]

§234(e)

(5) *has in effect an overall plan and budget that meets the requirements of subsection (2); and*¹

[(5)] (6) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) who is under the care of a physician (as defined in section 1861(r)(1)), and

(2) with respect to whom a plan prescribing the type, amount, and duration of physical therapy services that are to be furnished such individual has been established, and is periodically reviewed, by a physician (as so defined);

excluding, however—

(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

Sec. 1861(p)

(i) provides an adequate program of physical therapy services for outpatients and has the facilities and personnel required for such program or required for the supervision of such a program, in accordance with such requirements as the Secretary may specify,

(ii) has policies, established by a group of professional personnel, including one or more physicians (associated with the clinic or rehabilitation agency) and one or more qualified physical therapists, to govern the services (referred to in clause (i)) it provides,

(iii) maintains clinical records on all patients,

(iv) if such clinic or agency is situated in a State in which State or applicable local law provides for the licensing of institutions of this nature, (I) is licensed pursuant to such law, or (II) is approved by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, or

(B) if furnished by a public health agency, unless such agency meets such other conditions relating to health and safety of individuals who are furnished services by such agency on an outpatient basis, as the Secretary may find necessary.

§251(a)(1)

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility.

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§251(b)(1)

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§283(a)

The term "outpatient physical therapy services" also includes speech pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.

1/ Applies to services furnished on or after July 1, 1973.

2/ Applies to services furnished on or after date of enactment.

3/ Applies to services rendered after December 31, 1972.

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Physicians' Services

§227(f)

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls **[(but not including services described in the last sentence of subsection (b))]** *(but not including services described in subsection (b)(6))* **]** *1/*

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a

1/ Applies to accounting periods beginning after June 30, 1973.

§256(b)

physician within the meaning of section 1101(a)(7)), (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2) (E) of this Act¹ [or] (3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses,² or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine

§264(a)

(to correct a subluxation demonstrated by x-ray to exist)

§273(a)(1)

which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.³ For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.⁴

§211(c)(2)

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services;

(1) physicians' services;

(2) (A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

¹ Applies to admissions occurring after the second month following the month of enactment.

² Applies only with respect to services performed on or after the date of enactment.

³ Applies to services furnished after June 30, 1973.

⁴ Applies to services furnished with respect to admissions occurring after December 31, 1972.

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- (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study and ;
- (D) outpatient physical therapy services;

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased;

(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

§252(a) (8) prosthetic devices (other than dental) which replace all or part of an internal body organ (*including colostomy bags and supplies directly related to colostomy care*)^{1/} including replacement of such devices; and

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality, responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

(12) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

^{1/} Applies to items furnished on or after date of enactment.

(13) is furnished under arrangements referred to in such paragraph (2) (C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2) (A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Drugs and Biologicals

(t) The term "drugs" and the term "biologicals", except for purposes of subsection (m) (5) of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopocia, the National Formulary, or the United States Homeopathic Pharmacopocia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospitals.

Provider of Services

(u) The term "provider of services" means a hospital, [extended care] skilled nursing facility, [or] home health agency, or, for purposes of section 1814(g) and section 1835(e), a fund.³

Reasonable Cost

(v) (1) (A) The reasonable cost of any services shall be *the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be*⁵ determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in

¹ Applies to eligible drugs furnished on and after July 1, 1973.

² Applies to accounting periods beginning after ~~December 31, 1972~~ June 30, 1973

³ Effective with respect to accounting periods beginning after December 31, 1972.

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§223(b)

§223(c)

§223(d)

determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services¹ *may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title,*¹ and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall **[(A) take]** *(i) take* into account both direct and indirect costs of providers of services *(excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title)*² in order that, under the methods of determining costs, the **[costs with respect]** *necessary costs of efficiently delivering covered services*³ to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and **[(B) provide]** *(ii) provide* for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) *Where a hospital has an arrangement with a medical school*

¹ Effective with respect to accounting periods beginning after December 31, 1972.

² Effective with respect to accounting periods beginning after December 31, 1972.

³ Effective with respect to accounting periods beginning after December 31, 1972.

under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

- (i) *for which payment may be made under part A, but only if*
 - (I) *payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and*
 - (II) *such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or*
- (ii) *for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.*¹

(D) *Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B) (i) and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).*²

(E) *Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing provisions of this subparagraph shall not apply to any skilled nursing facility in such State if—*

- (i) *such facility is a distinct part of or directly operated by a hospital, or*
- (ii) *such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.*

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reason—

¹ Applies to accounting periods beginning after ~~December 31, 1972~~

² Applies to accounting periods beginning after ~~December 31, 1972~~

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able cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of the costs determined by the application of this subparagraph (without regard to such clause (ii)).

Certification and Approval of Skilled Nursing Facilities

(2) (A) If the bed and board furnished as part of inpatient hospital services (including inpatient *tuberculosis* hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient *tuberculosis* hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or **[extended care]** *skilled nursing* facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

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(4) *If a provider of services furnishes items or services to an individual which are ~~substantially~~ in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866 (a) (2) (B) (ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.*¹

§223(f)

(5) (A) *Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organiza-*

¹ Effective with respect to accounting periods beginning after December 31, 1972.

tion specified in the first sentence of section 1861(p), the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for travel time and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.¹

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.²

(6) [4] For purposes of this subsection, the term, "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

Arrangements for Certain Services

(w) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, [extended care] a skilled nursing facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Post-Hospital Extended Care in Christian Science [extended care] Skilled Nursing Facilities

(y) (1) The term "[extended care] skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified,

¹ Effective with respect to accounting periods beginning on or after December 31, 1972.

² Effective with respect to accounting periods beginning on or after December 31, 1972.

by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a) (2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

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(2) *Notwithstanding* any other provision of this title, payment under part A may not be made for services furnished an individual in [an extended care] *a skilled nursing* facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in [an extended care] *a skilled nursing* facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in [an extended care] *a skilled nursing* facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in [an extended care] *a skilled nursing* facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in [an extended care] *a skilled nursing* facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in [an extended care] *a skilled nursing* facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a) (3)).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

*Institutional Planning*¹

(2) *An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall be considered sufficient if it—*

(1) *provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any*

¹ Applies to any provider of services for fiscal years (of such provider) beginning after the fifth month following the month of enactment.

budget, an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of \$100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.

§234(f)

Exclusions From Coverage

Sec. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(2) for which the individual furnished such items or services

1/ Applies to fiscal years beginning after fifth month following month of enactment.

has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in such cases as the Secretary may specify;

§211(c)(1)

(4) which are not provided within the United States (except for **[emergency]** inpatient hospital services furnished outside the United States under the conditions described in section 1814(f) *and, subject to such conditions, limitations, and requirements as are provided under or pursuant to this title, physicians' services and ambulance services furnished an individual in conjunction with such inpatient hospital services but only for the period during which such inpatient hospital services were furnished*);¹

(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations;

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household;

§256(c)

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, *except that payment may be made under part A in the case of inpatient hospital services in connection with a dental procedure where the individual suffers from impairments of such severity as to require hospitalization*;² or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can

¹Applies to services furnished with respect to admissions occurring after Dec. 31, 1972.

²Applies to admissions occurring after the second month following the month of enactment.

reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

(c) *No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual on or after January 1, 1975, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that such plan or the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that—*

(1) there is available to each Federal employee or annuitant enrolled in such plan, upon becoming entitled to benefits under part A or B, or both parts A and B of this title, in addition to the health benefits plans available before he becomes so entitled, one or more health benefits plans which offer protection supplementing the protection he has under this title, and

(2) the Government or such plan will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of his coverage under this title, or (C) a combination of such contribution and such payment.

(d) (1) *No payment may be made under this title with respect to any item or services furnished to an individual by a person where the Secretary determines under this subsection that such person—*

(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title;

(B) has submitted or caused to be submitted (except in the case of a provider of services), bills or requests for payment under this title containing charges (or in applicable cases requests for payment of costs to such person) for services rendered which the Secretary finds, with the concurrence of the appropriate program review team appointed pursuant to paragraph (4), to be substantially in excess of such person's customary charges (or in applicable cases substantially in excess of such person's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges (or in applicable cases, such costs); or

(C) has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appro-

appropriate program review team appointed pursuant to paragraph (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of inpatient hospital services, post-hospital extended care services, and home health services such determination shall be effective in the manner provided in section 1866(b) (3) and (4) with respect to terminations of agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(4) For the purposes of paragraph (1) (B) and (C) of this subsection, and clause (F) of section 1866(b)(2), the Secretary shall, after consultation with appropriate State and local professional societies, the appropriate carriers and intermediaries utilized in the administration of this title, and consumer representatives familiar with the health needs of residents of the State, appoint one or more program review teams (composed of physicians, other professional personnel in the health care field, and consumer representatives) in each State which shall, among other things—

(A) undertake to review such statistical data on program utilization as may be submitted by the Secretary,

(B) submit to the Secretary periodically, as may be prescribed in regulations, a report on the results of such review, together with recommendations with respect thereto,

(C) undertake to review particular cases where there is a likelihood that the person or persons furnishing services and supplies to individuals may come within the provisions of paragraph (1) (B) and (C) of this subsection or clause (F) of section 1866(b) (2), and

(D) submit to the Secretary periodically, as may be prescribed in regulations, a report of cases reviewed pursuant to subparagraph (C) along with an analysis of, and recommendations with respect to, such cases.

§229(a)

Consultation With State Agencies and Other Organizations To Develop Conditions of Participation for Providers of Services

Sec. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections

(c) (8), (f) (4), (g) (4), (j) (10), and (o) (5)

of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or [extended care] *skilled nursing* facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency

or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p) (4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, [extended care] *skilled nursing* facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. *Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the*

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§299D(a)

major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

§244(a)

(c) *The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on the Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).*

Effect of Accreditation

[Sec. 1865. Except as provided in the second sentence of section 1863, an institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861(e) (6).**]**

Sec. 1865. (a) *Except as provided in subsection (b) and the second sentence of section 1863, if—*

(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

(2) such institution (if it is included within a survey described in section 1864(c)) authorizes the Commission to release to the Secretary (on a confidential basis) upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

(3) paragraph (6) thereof, and

Sec. 1865(b)

(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

§244(b)(1)

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose) or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with section 1861 (e) (6) or the standard described in such paragraph (4) as the case may be. In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

§244(b)(2)

(b) Notwithstanding any other provision of this title, if the Secretary finds following a survey made pursuant to section 1864(c) that an institution has significant deficiencies (as defined in regulations pertaining to health and safety), such institution shall, after the date of notice of such finding to the hospital and for such period as may be prescribed in regulations, be deemed not to meet the requirements of the numbered paragraphs of section 1861(e).

Agreements With Providers of Services

§227(d)(2)

Sec. 1866. (a) (1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e))¹ shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year

¹ Applies to accounting periods beginning after ~~December 31, 1972~~ June 30, 1973.

§281(c)

*period to not less than one year if he finds such reduction is consistent with the objectives of this title, and*¹

[(B)] (C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.

*An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12 month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.*²

§249A(b)

(2) (A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a) (1) or (a) (3), section 1833(b), or section 1861(y) (3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B. In the case of items and services described in section 1833(c), clause (ii)

of the preceding sentence shall be applied by substituting for 20 per centum the proportion which is appropriate under such section.

(B) (i) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

⁴(ii) *Where a provider of services customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this title and which have not been requested by such individual, such provider may (except with respect to emergency services) also charge such individual or other person for such more expensive items or services to the extent that the costs of (or, if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed*

¹ Applies in the case of notices sent to individuals after 1968.

² Effective with respect to agreements filed with the Secretary under section 1866 by skilled nursing facilities (as defined in section 1861(j)) before, on, or after date of enactment, but accepted by him on or after such date.

³ Applies with respect to eligible drugs furnished on and after July 1, 1973.

⁴ Effective with respect to accounting periods beginning after December 31, 1972.

Sec. 1866(b)

exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

(I) the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this title on account of costs *in excess of the costs determined to be necessary in the efficient delivery of needed health services under this title by particular providers of services in the area in which such items or services are furnished, and*

(II) the provider of services has identified such charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs *in excess of the cost determined to be necessary in the efficient delivery of needed health services under this title.* ^{1/}

§223(e)

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2), except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined) and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

(D) Where a provider of services customarily furnishes items or services which are *in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of section 1866(a)(2)(B)(ii), charge any individual or other person any amount for such items or services in excess of the amount of the payment which may otherwise be made for such items or services under this title if the admitting physician has a direct or indirect financial interest in such provider.* ^{1/}

For purposes of [clause (iii) of the preceding sentence] subparagraph (C),¹ whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1813(a)(2).

(b) An agreement with the Secretary under this section may be ~~terminated—~~ terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1))—^{2/}

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

¹ Effective with respect to accounting period beginning after December 31, 1972.

² See footnote to § 1866(a)(1)(B).

§223(g)(1)

§223(g)(2)

§249A(c)

§229(b)

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1861, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information, or (D) *that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this title or for use in determining the right to a payment under this title, or (E) that such provider has submitted, or caused to be submitted, requests for payment under this title of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1862 (d) (4) who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.*

Any termination shall be applicable—

[(3) in the case of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital service) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after the effective date of such termination,]

§249A(c)

(3) *in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination, ^*

(4) (A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

(c) (1) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not

1/ See footnote to § 1866 (a)(1)(B).

Sec. 1866(d)

file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

(2) *In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910, and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.*¹

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or [extended care] *skilled nursing* facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of [an extended care] *a skilled nursing* facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency

or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B),

but only with respect to the furnishing of outpatient physical therapy services, (as therein defined)

Health Insurance Benefits Advisory Council

Sec. 1867. [(a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise

¹ Effective with respect to agreements filed with the Secretary under section 1866 by skilled nursing facilities (as defined in section 1861(j)) before, on, or after the date of enactment, but accepted by him on or after such date.

² Applies to services rendered after December 31, 1972.

³ Applies to services rendered after December 31, 1972.

⁴ Applies with respect to services rendered after December 31, 1972.

in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Advisory Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 5 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.■

(a) *There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.*

§288(a)

Sec. 1867(b)

[(b) It shall be the function of the Advisory Council (1) to advise the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, and (2) to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Advisory Council shall make an annual report to the Secretary on the performance of its functions, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.]

§288(b) *(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.*

§288(c) [(c) The Advisory Council is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Advisory Council such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Advisory Council may require to carry out its functions.]

Sec. 1868. [Repealed.]

Determinations; Appeals

Sec. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

[(b) Any individual dissatisfied with any determination under subsection (a) as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is \$100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is \$1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).]

Sec. 1869 (e)

(b) (1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or ✓

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or ✓ *Λ*

Sec. 1869 (b)

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero) ^

2 ✓

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than \$1,000. ^

2 ✓

§2990(a)

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Overpayments on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals

Sec. 1870. (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

2/ Effective with respect to any claims under part A of title XVIII of such Act, filed--

- (A) in or after the month in which this Act is enacted, or
- (B) before the month in which this Act is enacted, but only if a civil action with respect to a final decision of the Secretary of Health, Education, and Welfare on such claim has not been commenced under such section 1869(b) before such month.

(b) Where—

§281(a)(1)(A)

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) *that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or*¹

(2) any payment has been made under section 1814(e) to a provider of services or other person for items or services furnished an individual,

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made. *For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.*²

§281(a)(2)

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault [and where] *or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b) (4), if*³ such adjustment (or recovery) would defeat the purposes of title II *or title XVIII*⁴ or would be against equity and good conscience. *Adjustment or recovery of an incorrect payment*

§261(a)

§281(b)(1)

¹ Applies to notices of payment sent to individuals after date of enactment.

² Applies to notices sent to individuals after 1968.

³ Applies to waiver actions considered after the date of enactment.

⁴ Applies to notices sent to individuals after 1968.

Sec. 1870(d)

(or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862 and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.¹

§281(b)(2)

(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

(e) If an individual, who received services for which payment may be made to such individual under this title, dies, and payment for such services was made (other than under this title), and the individual died before any payments due him under this title with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if the payment for such services was made (before or after such individual's death) by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations to have paid for such services, or if the payment for such services was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any;

(2) if there is no person who meets the requirements of paragraph (1), to the person, if any, who is determined by the Secretary to be the surviving spouse of the deceased individual and who was either living in the same household with the deceased at the time of his death or was, for the month in which the deceased individual died, entitled to a monthly benefit on the basis of the same wages and self-employment income as was the deceased individual;

(3) if there is no person who meets the requirements of paragraph (1) or (2), or if the person who meets such requirements dies before the payment due him under this title is completed, to the child or children, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such child, in equal parts to each such child);

(4) if there is no person who meets the requirements of paragraph (1), (2), or (3), or if each person who meets such require-

¹ Applies to notices sent to individuals after 1968.

ments dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual who were, for the month in which the deceased individual died, entitled to monthly benefits on the basis of the same wages and self-employment income as was the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent) ;

(5) if there is no person who meets the requirements of paragraph (1), (2), (3), or (4), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual;

(6) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), or (5), or if each person who meets such requirements dies before the payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of the deceased individual (and, in case there is more than one such child, in equal parts to each such child) ;

(7) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), or (6), or if each person who meets such requirements dies before the payment due him under this title is completed, to the parent or parents, if any, of the deceased individual (and, in case there is more than one such parent, in equal parts to each such parent) ; or

(8) if there is no person who meets the requirements of paragraph (1), (2), (3), (4), (5), (6), or (7), or if each person who meets such requirements dies before the payment due him under this title is completed, to the legal representatives of the estate of the deceased individual, if any.

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a) (1) dies, and—

(1) no assignment of the right to payments was made by such individual before his death, and

(2) payment for such services has not been made, payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.

(g) If an individual, who is enrolled under section 1818(c) of the Social Security Act or under section 1837, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (c).

Regulations

Sec. 1871. The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

Application of Certain Provisions of Title II

§242(a)

Sec. 1872. The provisions of sections 206, [208,] and 216(j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

Designation of Organization or Publication by Name

Sec. 1873. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

Administration

Sec. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1937, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

§289

(c) *In the course of any hearing, investigation, or other proceeding that he is authorized to conduct under this title, the Secretary may administer oaths and affirmations.*

Studies and Recommendations

§201(c)(7)

Sec. 1875. (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the [aged] *aged and the disabled*, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

1/ Does not apply to any acts, statements, or representations made or committed prior to enactment.

- §244(d) (b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B (including a *validation of the accreditation process of the Joint Commission on the Accreditation of Hospitals, the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972,*¹ the [experimentation] *experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967, and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972*), and shall transmit to the Congress annually a report concerning the operation of such programs.
- §226(d)
- §222(c)

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1876. (a) (1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

- §226(a) (A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and
- (B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under part B.

¹ Effective with respect to services provided on or after July 1, 1973.

² Effective with respect to services provided on or after July 1, 1973.

Sec. 1876(a)

(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3) (A) (iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capita costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (c). Each such organization shall submit interim estimated cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretary shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

(3) (A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i) (2) (A), payments made to such organization shall be subject to the following adjustments at the end of each contract year:

(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as 'savings') shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the 'Medicare Trust Funds') as follows:

(I) savings up to 20 percent of the adjusted average per capita cost shall be apportioned equally between such organization and the Medicare Trust Funds;

(II) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resulting difference (hereinafter referred to as 'losses'), shall be absorbed by such organization, and shall be carried forward and offset from savings realized in later years, with the apportionment of savings being proportional to the losses absorbed and not yet offset;

(iii) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

(I) within 90 days after close of a contract year, interim determination of the amount of estimated savings and apportionment thereof shall be made, actuarially, on the basis of interim reports of costs incurred by an organization, and

§226(a)

(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v) of the Social Security Act; and

(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

(4) The payments to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a) (1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

§226(a)

(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839 (c) (1), and

(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839 (c) (4).

The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(b) The term 'health maintenance organization' means a public or private organization which—

(1) provides, either directly or through arrangements with others, health services to individuals enrolled with such organization on the basis of a predetermined periodic rate without regard to the frequency or extent of services furnished to any particular enrollee;

(2) provides, either directly or through arrangements with others, to the extent applicable in subsection (c) (through institutions, entities, and persons meeting the applicable requirements of section 1861), all of the services and benefits covered under parts A and B of this title which are available to individuals residing in the geographic area served by the health maintenance organization;

(3) provides physicians' services primarily (A) directly through physicians who are either employees or partners of such organization, or (B) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a

Sec. 1876(c)

per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis;

(4) provides either directly or under arrangements with others, the services of a sufficient number of primary care and specialty care physicians to meet the health needs of its members; for purposes of this section the term "specialty care physician" means a physician who is either board certified or eligible for board certification, except that the Secretary may by regulation prescribe conditions under which physicians who have a record of demonstrated proficiency but who are not eligible for board certification may, on the basis of training and experience, be recognized as specialty care physicians;

(5) has effective arrangements to assure that its members have access to qualified practitioners in those specialties which are generally available in the geographic area served by the health maintenance organization;

(6) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;

(7) except as provided in subsection (h), has at least half of its enrolled members consisting of individuals under age 65;

(8) assures that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and

(9) has an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of paragraph (7)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.

(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) shall consist of—

(1) in the case of an individual who is entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B—

(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health

§226(a)

adjusted average per capita costs incurred (as defined herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the Trust Funds shall be paid by such organization or the Secretary as appropriate;

(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph; and

(III) where such final settlement is reached more than 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

(iv) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in the geographic area served by a health maintenance organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

§226(a)

(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i) (2) (B), payments made to such organization shall be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

Sec. 1876(d)

maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the health maintenance organization with which he is enrolled; and

(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

(d) Subject to the provisions of subsection (c), every individual described in subsection (c) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health service to which he believes he is entitled shall, if the amount in controversy is \$100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is \$1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

§226(a)

(g)(1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c), its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion applicable to the services described in subsection (c) may not exceed (i) the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section less (ii) the actuarial value of other charges made in lieu of such deductible and coinsurance.

(h) The provisions of paragraph (7) of subsection (b) shall not apply with respect to any health maintenance organization for such period not to exceed three years from the date such organization enters into an agreement with the Secretary pursuant to subsection (i), as the Secretary may permit, but only so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plans for each year that it is making continuous efforts and progress toward achieving compliance with the provisions of such paragraph (7) within such three-year period.

(i)(1) Subject to the limitations contained in subparagraphs (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of indi-

viduals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

(2) (A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 persons in each of the two years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immediately preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings, as determined pursuant to subsection (a) (3) (A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health maintenance organization which has entered into a risk-sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

§226(a)

(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear the risk of potential losses as determined under clause (ii) of subsection (a) (3) (A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects, or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (a) (3) (B).

(3) Such contract may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and extended care facilities for the reasonable cost (as determined under section 1861(v)) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or extended care facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any

Sec. 1876(j)

time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

(6) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

(B) shall provide that no reinsurance costs (other than those with respect to out-of-area services), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iii) of subsection (a)(3)(A), shall be allowed for purposes of determining payments authorized under this section; and

(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purposes of this title.

§226(a)

SEC. 1877. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to any such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(b) Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or

(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services,

shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency (as those terms are defined in section 1861), shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$2,000 or imprisoned for not more than 6 months, or both.

§242(b)

Sec. 1878

PROVIDER REIMBURSEMENT REVIEW BOARD ✓

SEC. 1878. (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the 'Board') which shall be established by the Secretary in accordance with subsection (h), if—

(1) such provider—

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is \$10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1) (A) or with respect to appeals pursuant to paragraph (1) (B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the \$10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, \$50,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rules of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 205 with respect to subpoenas

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shall apply to the Board to the same extent as they apply to the Secretary with respect to title II.

§243(a)

(f) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies (adversely to such provider) the Board's decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within 60 days of the date he is notified of the Secretary's reversal or modification. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

(g) The finding of a fiscal intermediary that no payment may be made under this title for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1862 shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f).

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of title 5, United States Code. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions."

LIMITATION ON LIABILITY OF BENEFICIARY WHILE MEDICARE CLAIMS
ARE DISALLOWED 1/

Sec. 1879. (a) Where—

(1) a determination is made that, by reason of section 1862(a) (1) or (9), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b) (3) (B) (ii), and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B,

then to the extent permitted by this title, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this title), as though section 1862(a) (1) and section 1862(a) (9) did not apply. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services.

(b) In any case in which the provisions of paragraphs (1) and (2) of subsection (a) are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred to in such paragraphs), subject to the deductible and coinsurance provisions of this title, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services.

(c) No payments shall be made under this title in any cases in which the provisions of paragraph (1) of subsection (a) are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B by reason of section 1862 (a) (1) or (a) (9).

(d) In any case arising under subsection (b) (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c), the provider or other person shall have the same rights that an individual has under section 1869(b) (when the determination is under part A) or section 1842(b) (3) (C) (when the determination is under part B) when the amount of benefit or payments is in controversy, except that such rights may, under prescribed regulations, be exercised by such provider or other person only after the Secretary determines that the individual will not exercise such rights under such sections.

§213(a)

1/ Applies to claims under part A or part B files with respect to items or services furnished after date of enactment.

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